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ABSTRACT

This practicum promoted community, school, and agency collaborative relationships to increase the access and affordability of comprehensive, culturally acceptable health care services and health promotion activities. The target population for these services and activities were high-risk, minority adolescents in grades 6 through 8 in two elementary schools serving Latino, African-American, Caucasian, and Asian-American students, including several immigrants. The primary partners were the local health center, Planned Parenthood, and school personnel. Public school nursing staff facilitated health assessments and access for students who needed services. The 8-month school-based Young Adolescent Health Project included health screenings, appointments, advocacy, transportation, education, dental and vision care, laboratory tests, management of chronic illnesses, gynecological/reproductive services, and individual counseling. Workshops and peer health education were used to teach health-promoting behavior. Additional strategies used to address issues of accessibility, availability, affordability, and acceptability included nontraditional outreach, a data management system, and the employment of bilingual and bicultural staff, with selected eighth graders serving on an advisory council. Evaluation of the project indicated that health assessments identified many unmet physical health needs of young adolescents. Identified mental health needs were addressed by counselors in the School Based Youth Service Program. Overall, this project resulted in increased accessibility to health care for this population. Subsequently, an information management system was developed to allow service providers to share relevant information about the medical needs of identified students, and existing relationships among partners were strengthened. (Six appendices include a Health History Assessment, Treatment Plan Contact Sheet, and a Parent Consent Form. Contains 36 references.) (KB)

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Developing a Young Adolescent Health Project to Provide Primary and Preventive Services in Schools

By

Gail Reynolds
Cluster 65

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A Practicum II Report Presented to the
Ed.D. Program in Child and Youth Studies
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

Nova Southeastern University
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PRACTICUM APPROVAL SHEET

This practicum took place as described.

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October 17, 1996

This practicum report was submitted by Gail Reynolds under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Child and Youth Studies and approved in partial fulfillment of the requirement for the degree of Doctor of Education at Nova University.

Approved:

2-19-97
Date of Final Approval of Report

Roberta Silfen
Roberta Silfen, Ed.D., Adviser

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I would like to express my sincere appreciation to my collaborative partners in the Alliance for Teen Health for their support and commitment to developing and maintaining the health project. The ATH is grateful to the United Way of Central New Jersey for the opportunity to demonstrate the efficacy of such a model for children's health care.

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ABSTRACT

Developing a Young Adolescent Health Project to Provide Primary and Preventive Services in Schools. Reynolds, Gail, 1996: Practicum Report, Nova Southeastern University, Ed.D. Program in Child and Youth Studies. Adolescent health needs/Programming/Interagency Collaboration.

The problem encountered in this community was the lack of an interagency collaborative plan to provide coordination for the health services for young adolescents in grades six through eight. This group of high-risk, minority students were in need of primary health care and access to appropriate services to support their medical, dental, and vision needs. Many of the families had neither the resources nor the ability to access needed services for their children. There was also no system in place to efficiently track students for continuous care management across health providers, schools and other agencies.

This practicum was designed to promote community, school and agency collaborative relationships as a means to increase access, affordability, and culturally acceptable health care for young adolescents. The primary partners in the project included the local health center, Planned Parenthood, and school personnel. The public school nursing staff helped to facilitate health assessments and access for students who needed services.

The health assessment identified many unmet physical health needs of young people. The assessment also identified mental health needs which were addressed by counselors in the School Based Youth Service Program. Through the access provided by this project, health care services became more accessible to this population. In addition, a management of information system was developed to allow service providers to share relevant information about the medical needs of the identified students. The collaboration also strengthened existing relationships among the partners.

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CHAPTER I

INTRODUCTION

Description of the Community

The community in which the practicum was implemented was a small, urban city in the central part of the eastern United States. According to the 1990 report by the U.S. Bureau of Census, it had a population of approximately 43,000. The ethnic breakdown in the city was 49.4% Caucasian, 27.3% African American, 19.3% Latino, and 4% Asian. Latino residents were the newest ethnic group and the fastest growing segment of the population. While the Latino residency in this city was less than 50 years old, there had been rapid growth in the last 20 years. Between 1980 and 1990 there was a 65 percent increase in the Latino population. The State Office of Minority Health attributed this growth to increased migration from the Caribbean and Latin America as well as a high birth rate and an improved census count.

This city had many other distinguishing features as well as many resources. As the county seat, it was a cultural center with two major theaters one of which was the state's premiere African-American theater. It was also the medical hub for the central part of the state with two major hospitals, two pharmaceutical companies, the Medical School and the State University.

The city's rich history dated back to its charter of 1730. It has played a major role in the health and welfare of the state and the country. The catalyst for the development of modern medicine in this community goes back to a very important historical period, the French and Indian Wars of 1756 to 1763. The city was a staging area for the British expeditionary force that came to fight the French and Indians. Not only were the British troops based in the city, but their medical units stayed with the troops. For the first time, doctors in the area saw the modern medicine of that day as practiced by the medical corps and medical officers of the British expeditionary force. Inspired by a group approach to medicine as modeled by the British medical corps, practitioners in this city formed the first medical society in the colonies at that time. Organized medicine as we know it today began in this city. The Medical Society's founding principles were "mutual improvement, professional advancement and the promotion of the public good" (Reitman, 1982, p.112).

Another important event associated with this city was the licensing of physicians. During the early years of medicine, anyone who wanted to be a doctor could attain that status. There were no attempts at licensing in the United States until 1772 when Dr. John Chochran, a well-known physician in the city, spearheaded the passing of the act "to regulate the practice of the physic and surgery within the colony" (Reitman, 1982, p. 112). The licensing of physicians and the development of the first Medical Society in the United States had its beginnings in this city.

This city has produced other major contributions in the medical field through the development of two major hospitals founded between 1885 and 1900. Dr. Frederick Kilmer, the scientific director of Johnson and Johnson, played a major role in originating the idea of chemical sterilization and mechanical cleanliness through his booklet entitled Modern Methods of Antiseptic Wound Treatment. This advancement in medical care was enhanced by the company's manufacture of antiseptic surgical dressings. The importance of the company's role was not only limited to products, but it became the center of reliable information on new approaches to surgery and patient care at the turn of the century (Foster, 1986).

Writer's Work Setting and Role

The writer was the Director of the School Based Youth Services Program (SBYSP) located in the city's public schools. There were 30 similar programs funded by the state that provided services to middle and high school students. Figure 1 portrays the interventions and projected outcomes of all SBYSPs.

The SBYSP in this city was the largest in the state, serving children pre-kindergarten through high school. It was comprised of three separate programs: high school, elementary, and a parent-infant care center for parenting students. This program provided health, mental health, substance abuse prevention, teen parenting and employment services as well as social and recreational activities for the 5000 students enrolled in the nine public schools. In the high school, mental health and teen parenting services were given priority and were developed from the inception of the program. In contrast to other communities in the state, the health services of this SBYSP were limited to only emergency care during the first few years of operation.

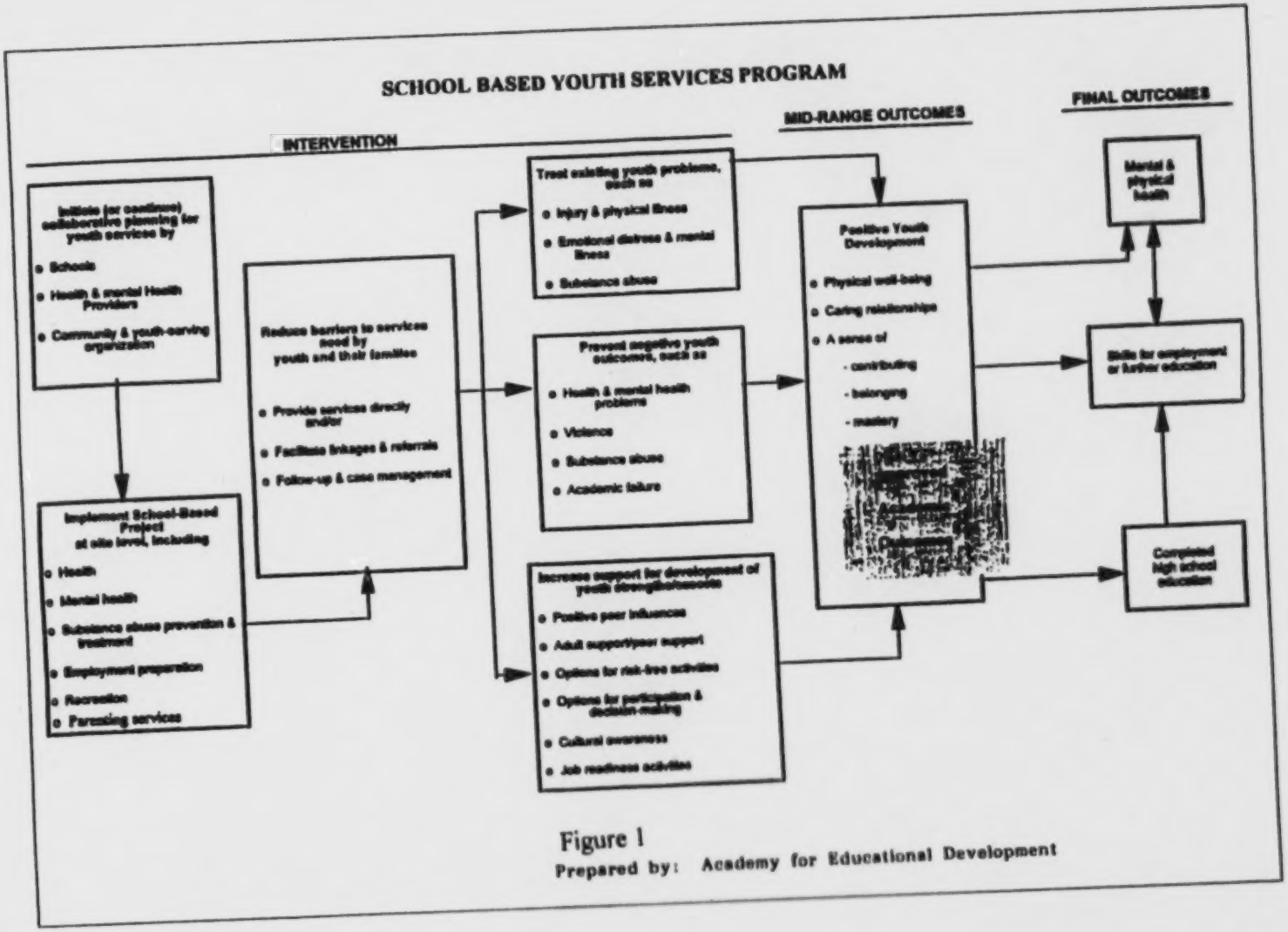
SCHOOL BASED YOUTH SERVICES PROGRAM
INTERVENTION
MID-RANGE OUTCOMES
FINAL OUTCOMES
Initiate (or continue) collaborative planning for youth services by
o Schools
o Health & mental Health Providers
o Community & youth-serving organization
Implement School-Based Project at site level, including
o Health
o Mental health
o Substance abuse prevention & treatment
o Employment preparation
o Recreation
o Parenting services
Reduce barriers to services need by youth and their families
o Provide services directly and/or
o Facilitate linkages & referrals
o Follow-up & case management
Treat existing youth problems, such as
o Injury & physical illness
o Emotional distress & mental illness
o Substance abuse
Prevent negative youth outcomes, such as
o Health & mental health problems
o Violence
o Substance abuse
o Academic failure
Increase support for development of youth strengths/resources
o Positive peer influences
o Adult support/peer support
o Options for risk-free activities
o Options for participation & decision-making
o Cultural awareness
o Job readiness activities
Positive Youth Development
o Physical well-being
o Caring relationships
o A sense of
- contributing
- belonging
- mastery
Mental & physical health
Skills for employment or further education
Completed high school education

Figure 1

Prepared by: Academy for Educational Development

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The SBYSP represented a collaborative partnership among the University of Medicine and Dentistry-University Behavior HealthCare, a city redevelopment agency, the Board of Education and the State Department of Human Services. Although it was designed to develop comprehensive on-site services, this particular SBYSP chose to emphasize mental health services. The staff were trained mental health clinicians who provided individual, group, and family therapy to students and their families. Educators and child care specialists staffed the teen parenting program. They often joined with health providers to motivate and promote primary prevention through information and skills training. Primary care was not offered to the children until a health collaborative partnership was formed.

The development of this health partnership was organized around the same theoretical approach that was used to develop the SBYSP. The emphasis was on collaborative relationships with agencies that were interested in serving children and adolescents. Consequently, the Alliance for Teen Health (ATH) was formed between the local Federally Qualified Health Center, Planned Parenthood, the School District, and the SBYSP. A grant proposal was written to the State Department of Health to develop health services for the high school in 1991. In 1995, this group submitted a grant proposal to the local United Way to expand its services to 6th, 7th and 8th grade students. This service expansion of the ATH was called the Young Adolescent Project. Spanish speaking immigrants and other adolescents of color were targeted in this grant as the population with special unmet health care needs.

The practicum took place in two elementary schools with the largest immigrant Latino populations. One elementary school had a population of 790 students. The ethnic breakdown of this school was as follows: 496 students (62%) were Latino, 293 students (37%).were African- American, 9 students (1%) were Caucasian. The other elementary school had a total of 690 students enrolled: 456 students (66%) were Latino, 221 (32%) were African-American, 7 (1%) Caucasian, and 6 (1%) Asian. In this community, the Latino-American subgroups included Dominicans, Mexicans, Puerto Ricans, and Central and South Americans. The most recent Latino arrivals were from Central America and the Dominican Republic. Many of the Central Americans were fleeing political and economic turmoil, while the Dominicans were seeking to improve their economic condition. The school district had three specialized educational programs designed to teach basic skills to the Latino students. They were the Limited English Proficient Students' Program, Port of Entry Students' Program, and English as a Second Language Program. The SBYSP staff in these schools were bilingual and bicultural.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The problem encountered in this community was that the availability and accessibility of preventive and primary health care services for young adolescents were limited or non-existent for many of the 6th, 7th and 8th grade students. The school district had no middle school designation, therefore a large number of students in the elementary schools were adolescents who were approaching sexual maturity and confronting the dangers associated with adolescence. Poverty, cultural and language barriers, adolescent pregnancy, drug addiction, HIV infection, and murder played a major role in the high morbidity and mortality rates found in the city's adolescents (Garland, 1993).

While this city was considered a medical hub with considerable medical resources, a large segment of the population did not have access to medical care for many reasons. In 1990, this city was targeted by the State Department of Health as an underserved area where access to comprehensive health care for adolescents was very limited. A survey conducted by Third Power Market Development and the Eagleton Poll, Rutgers University (1993), identified several factors which inhibited access to health care providers by the residents.

They included: An inability to speak English; a perception that providers were insensitive to their needs; a lack of transportation; legal problems related to their immigrant status; and serious financial constraints. A follow-up survey will to be conducted by the Eagleton Institute in 1996 and 1997 to determine if health care accessibility has improved for the residents of the city. In addition to the identification of treatment accessibility, the new survey expects to probe for greater explanation of the medical problems faced by the city residents. The questions are tailored to assess the health needs of each individual as well as the perceived accessibility of services to meet their needs. At this particular time, the State has moved to a mandated managed care system for welfare recipients. There is a concurrent attempt to actively recruit Medicaid eligible clients to sign up with a particular Health Maintenance Organization (HMO). Consequently, it could be assumed that the perception of health care accessibility will improve during the initial period of moving Medicaid patients from the traditional health insurance model to the managed care model. The follow-up survey will reflect these changes in the health environment.

Even in an environment where the issue of accessibility may be temporarily abated, addressing adolescent health status indicators will be a far more difficult task than defining and treating the health needs of the adult population. The State managed care program failed to cover prevention services, despite the claim by the State that "emphasis is placed on the promotion of healthy attitudes and behaviors, and on collective and individual responsibility for disease prevention" (Whitman & Fishman, p. 1).

In order to promote child health, covered services needed to include not only traditional medical care, but also counseling, anticipatory guidance, and various information and educational activities that help develop healthy attitudes and behaviors. Several researchers have found the leading problems influencing the health and well being of children relate to at-risk behaviors. The state in which this practicum was conducted reported that the "unintentional injuries accounted for 34.2% of the total deaths in the 1-14 year old group, while unintentional injuries, homicide and suicide together caused 66.3% of all deaths in those 15-24 years old" (Whitman & Fishman, 1996 p. 3). The unintentional and intentional injuries have continued to increase since 1990 according to this report and is the leading cause of death for children (p. 37).

Fingerhut & Kleinman's study (as cited in Perrin, Guyer & Lawrence, 1992) also found adolescents, aged 10-19 years, were the only segment of the population in which mortality rates did not decline during the past two decades. "Seventy-three percent of the deaths that occur between the ages of 10 and 19 years can be attributed to intentional and unintentional injuries and violence" (Perrin, et al., p.66). African-American and Latino youth were also disproportionately affected by violence as victims and perpetrators. According to the analysts at the Centers for Disease Control (CDC), (as cited in Prothrow-Stith,1991) the murder rate of Africa-American males between the ages of 14-24 during 1984-1988 rose by 68%; the murder rate of the 15-19 year old group rose by 100% during the same period. (p.65) Recorded information has not identified data specific to Latino homicide. The FBI crime statistics, for example, classify Americans as black, white, or other.

As a result, no aggregate Latino-American homicide statistics were kept. However, the incidence of fatal violence for young Latino men were reported to be approximately three to four times greater than that of young White men of the same age. (National Center for Health Statistics, 1992) These studies indicate that in addition to the traditional medical services, health care for the adolescent population must also include educational and prevention activities if changes in attitudes and behaviors are to occur.

Educators are increasingly aware of the interconnectedness often between educational achievement and the health status of children. They have responded by developing categorical programs to increase positive outcomes for adolescents. They realize that the out-of-school experiences and behaviors, such as drug use, violent acts, high risk sexual activity and depression, were powerful influences on school performance. These health damaging behaviors greatly hampered the educational goals of many school systems and caused a growing crisis in youth development. Pentz (1982) suggested that youth are regressing in health and social well being. She further indicated that there was an increase in drug abuse, suicide, sexually transmitted diseases, pregnancy, homelessness, delinquency, crime, and unintentional deaths while healthy dietary and exercise habits, routine health care, and education were on the decrease. (p.15)

The mounting pressure placed on schools to tackle these ubiquitous social and health problems has been overwhelming. The recognition of the importance of non-educational needs has given renewed impetus for system changes. This change has not necessarily required schools to assume direct responsibility for these needs, but instead to insure that the issues are addressed.

Many schools have chosen to relieve the pressure by sharing responsibilities for non-school issues with community agencies through collaborative partnerships. By subscribing to the idea of mutual interdependence and cooperation, both schools and agencies have developed new and creative ways of delivering services. When health promotion and prevention efforts go beyond what is offered in any one setting or in any single discipline, collaboration among medical, public schools, and other community agencies is crucial to the delivery of services.

In summary, the problem that was addressed in this practicum was that the availability and accessibility of preventive health and primary care services for adolescents in the 6th, 7th and 8th grades in two schools were limited for some and non-existent for others. Therefore, in order to prevent and remediate the complex, interrelated problems faced by adolescents in this particular community, community building through collaboration presented a new strategy for delivering health care services to this population.

Problem Documentation

Evidence of the problem was documented by the health status reports of the local community health center, school health records, and a needs assessment conducted among the school nurses. 80 of the 6th, 7th and 8th grade students from two elementary schools agreed to participate in the practicum interventions by returning signed parental consent forms. These students ranged in age from 11 to 16 years old. 30 of these students were recent immigrants who arrived in this country without immunization, dental care, or any records that reflected prior health care.

Other students in this group presented with chronic health problems, including asthma and other respiratory problems that made them at-risk for health crises, and emergency room visits. The school nurse was unable to facilitate appropriate referrals and treatment for many of these students because communication with parents, often monolingual in their native language, was limited. It had been the experience of the school nurses that recommendations for treatment have not been followed by parents because they lacked the financial resources or did not understand the reasons for needed treatment. In addition, there were no primary physical health treatment services available in these 2 schools.

According to self-reports, 70% of the total population in these schools did not have a regular doctor and 80% had no dentist. This descriptive data is not confined to this city. The Children's Defense Fund Fact Book indicated that "a Latino teenager is twice as likely as a white teenager to have no health insurance" (Simons, Finlay, & Yang, 1991, p. 5). Additionally, Trevino, Moyer, Valdez, & Stoup-Benham (1991) analyzed data from two surveys, the Current Population Survey (CPS) and the Hispanic Health and Nutrition Examination Survey (HHANES) which showed Latinos were least likely to have insurance coverage for illness when compared to all other ethnic groups in the United States. More than one-third of the Mexican-American population, one-fourth of the Cuban-American population and, one-fifth of the Puerto Rican population, were uninsured for medical expenditures. When Trevino et al. (1991) compared these percentages to other populations, one-fifth of the non-Hispanic African-American and one-tenth of the White non-Hispanic population had no health insurance coverage.

In a needs assessment conducted in 1992 in this city, the 9 school nurses in the district indicated that dental and eye care were the most difficult services to access for their students. This information was supported by national surveys that collected and analyzed information about the health status of children. For example, the National Health Interview Survey (NHIS) conducted in 1992, indicated that poor children were significantly less likely to receive timely physical and vision examinations and preventive dental care than their non-poor counterparts. (Newacheck, Jameson, Halfon, 1994) According to this survey insurance coverage made the difference. "Poor children with insurance have been shown to use preventive services at about the same rate as non-poor children; but poor children without insurance coverage lag substantially behind their non-poor peers in the use of preventive services" (Newacheck, et.al., p. 232).

Despite increased access to health care through Medicaid over the past 30 years, income related gaps still existed in accessing health care. The Executive Director of the local community health center maintains that many physicians, dentists, and optometrists have not accepted Medicaid patients because the State had a history of low reimbursement rates that has never kept up with the cost of living increases over the years. A. Curran (personal communication, September 26, 1995) As a result of the insufficiency of the reimbursement, children who were Medicaid eligible still did not receive adequate dental or eye care. Although the health care reform underway in the State will probably expand availability, access to certain services such as dental care may be restricted through contractual exclusions. These exclusions give a health plan considerable discretion to legally withhold covered services from an individual plan member.

It appears that decisions about how long a child receives a service or if he is referred to a specialist depends on the discretion of the HMO. Although there were two clinics that provided sliding fee scale payment arrangements in this community, there was no organized free, or low cost health delivery system to meet the adolescent health needs of the poor children.

Causative Analysis

The causes of the inadequate availability and accessibility of health care for children and adolescents can be related to socioeconomic status, language barriers, and a fear of expulsion from the United States. Additionally, lifestyle and behavior, and cultural attitudes about social systems have affected health status in this community. According to the nurse's records, 60 of the 100 students are children of working low income families, and do not meet the requirements for Medicaid. Furthermore, the families of these children did not have employment related insurance coverage. Another problem experienced by these children was that many of their parents did not speak or read English. English illiteracy often resulted in the lack of sufficient and appropriate information for accessing health care.

There were other critical issues that have also affected the health status of Latino groups. These included cultural isolation, fear, and utilization skills. (Mendoza, 1994) Many of the Latino immigrants were fearful to communicate their needs because of the potential for expulsion from this country. Lack of knowledge about the types of medical and preventive ancillary services limited appropriate utilization.

African-American health status was not only affected by socioeconomic status, and lifestyle, but cultural attitudes about social systems. While African-Americans may not have had the fear associated with immigrant status, they were often cautious and distrustful of social systems. Some believed that these systems had a history of insensitivity to their needs and problems. When surveyed by the Third Power Market Development and the Eagleton Poll, et al, (pp 36-38) community residents indicated that local health providers were insensitive to the needs and customs of minorities.

The health status of children and adolescents has also been strongly related to family type and income. Approximately one-half of the student population of both schools live in mother-headed families. Single parent families generally have substantially lower family incomes than do two-parent families.

Relationship of the Problem to the Literature

The health of adolescents has been placed in jeopardy. They face behavioral and organizational barriers that have prevented them from receiving adequate health care. They have had serious but often preventable health problems. According to the Children's Defense Fund (1991) "every day seven teenagers are victims of homicide; every day 10 teenagers are killed by firearms; every day 39 youths ages 15 to 24 are killed in motor vehicle accidents" (p. 2). In addition systemic factors, such as availability, affordability, flexibility and coordination often interfere with adolescents receiving services.

The record number of adolescents in the 1990's who have engaged in numerous harmful and dangerous behaviors has contributed greatly to the crisis in the state of their health. According to Hechinger (1992), by age fifteen, about one quarter of all young adolescents are engaged in these behaviors. "Large numbers of ten-to fifteen-year-olds suffer from depression that may lead to suicide; they jeopardize their future by abusing illegal drugs and alcohol, and by smoking; they engage in premature, unprotected sexual activity; they are victims or perpetrators of violence; they lack proper nutrition and exercise" (p. 21).

Adolescents of color are two to three times more likely to have had more frequent and more severe health problems than their white counterparts, and are less likely to have had a usual source of health care or received any form of preventive care. (Isaacs, 1993, p.36) Mendoza (1994) pointed out that Latino children whose families were undocumented were most likely to suffer health problems, have little access to health care, and live in poverty. The health status of these young people were strongly related to their family's socioeconomic status. "Low income is responsible for much, if not most, of the disadvantages found among children in other high risk groups" (Starfield, 1992, p. 33) Since out-of-pocket cost can be an obstacle to health care, family income is significantly related to the probability of children's use of preventive services.

The relationship between Latino ethnicity, poverty and health access was discussed by Mendoza (1994) when he stated:

> Although Latinos have high rates of employment, they suffer from a number of problems that have a direct impact on their access to health insurance.

> First, they tend to work for small firms or in other industries that typically do not offer their employees health insurance. In addition, Latinos, . . . have a greater number of dependents per worker than do Anglos or Blacks, because of high birth rates (p. 68).

The economic condition of children of color in this country has increasingly worsened. "They are most often found to be overly represented in all the indices and conditions that give rise to poor health, namely: poverty, substandard housing, poor schools, low parental educational achievement, and single-parent households" (Isaacs, 1993, p.42). These children comprised 30 % of the population under the age of 19 years in 1990 and will comprise 33% by the year 2000. By the year 2030, children of color will increase by more than 52%, constituting 41% of all children in the United States (CDF,1991, p.23). Latino children alone are projected to increase to 22% of the child population by 2025 according to Lewit & Baker (1994). The economic condition of children of color in this country have increasingly worsened as their numbers have increased. "Children under age 18, who made up less than 20% of the poor Black population in 1970, were more than 45% in 1985." (Marshall, 1993, p.26). In 1991, 41% of all Latino children lived in poverty. While Latino children represented 11.6% of all children in the U.S., they were 21.5% of all children living in poverty. Mendoza,1994, p. 49) Finally, "one out of every two African-American children and at least two out of every five Latino children grow up in poverty, as compared to less than one in five White-American children" (Isaacs, 1993, p.36).

Newacheck, et al., (1994) analyzed the difference between poor and non-poor child health status by reviewing several national surveys sponsored by the National Center for Health Statistics (NCHS). Families with incomes below $10,000 annually were considered to be poor. They found that "poor children and adolescents experience significantly higher levels of vision and hearing problems, oral health problems (including periodontal disease, decayed and missing teeth, and malocclusion), nonacne skin lesions, and elevated blood lead levels than children from higher income families" (p.232). Evidence from this survey analysis further indicated that poor children not only experienced a disproportionate number of health problems, but were affected more severely. For example, in 1992 poor children had 32% more restricted activity days, 78% more bed days, and 55% more school absence days than children from non-poor families. (p. 231)

Single-parent households has been an increasing trend that has adversely affected the poverty rate in this country. Cunningham & Hahn (1994) analyzed data from the 1987 National Medical Expenditure Survey that indicated economic and social differences between two-parent and mother-headed families were striking. "Nearly one-third of children in mother-headed families did not have any insurance coverage (either public or private) for all or part of 1987 compared with nearly one-fourth of children in two-parent families" (p.29). The family formation patterns changed for many Americans, but the most pronounced changes occurred among African-Americans. According to Jencks (1989) the proportion of children born to unmarried African-American women rose from 23% to 61% during the period 1960-86 as compared to 2% to 16% among White women. (p.18)

"African-American women have historically had high rates of labor force attachment when compared with White women" (Franklin, Smith, McMiller, 1995, p. 142). However, this historic pattern does not hold for those women between the ages of 16 and 24 who have the highest fertility rates and the weakest attachment to the labor force. The researchers found that never married African-American mothers suffer more severe economic hardship and they are part of the group that are persistently poor.

It would be a flagrant omission to try to understand, explain, or attempt to work with African-American families or individual children without an antecedent analysis of the particular economic and cultural circumstances of the historical situation of African-Americans in this country. About twenty five years ago, Frantz Fanon, (as cited in Marshall,1993) an African-Caribbean psychiatrist offered a theoretical framework from which to think about these issues. He maintained that "established psychologists seek to explain everything by movements of the individual's psyche, deliberately leaving out of account the special political and economic character of the social situation" (p.23).

Racism is a psychosocial stressor that impacts on youth mental and physical health. Categorization, isolation, and discrimination are all important aspects of racism. In American society, institutional racism is often exhibited by attacks on affirmative action policies and a refusal to extend services to new immigrant families by the dominant cultural groups. Often, the young members of a subculture become victimized to such an extent that they do not believe that equality of opportunity exists for them.

Historical discrimination and racism have created a dynamic of difference which has resulted in distrust. (Isaacs, 1993) This author indicated that "the dynamics of difference play a major role in the lack of effectiveness of health prevention and promotion strategies developed by the dominant culture and placed on ethnic minority communities" (p. 45): For example, many African-Americans distrust those who preach about a "war on drugs" despite the fact that drugs present a major health risk in their communities. Nobles & Goddard (1993) noted that the cultural substance of a people develops like a special set of glasses that perceives situations that are meaningful and excludes those that are not. It is through these glasses that impressions are received, filtered, organized and transformed into mental impressions and behavioral dispositions and/or responses. (p.118)

It appears that the war on drugs result in a disproportionate number of deaths and incarcerations for African-American males. By contrast, "there is a lack of information about, and law enforcement attention to, the largely non-Black, wholesale drug dealers who make the marriage between the Colombian cartels and the Black retail drug dealers in inner-city and small-town America" (Marshall, 1993, p.27). If it is believed that the only players in this social epidemic have been Colombian cartels, African-American and Latino street dealers, then why is it not also true that they have the resources to manage and distribute the volume of drugs imported into this country. Marshall (1993) noted that "The U.S. House of Representatives Select Committee on Narcotics and Dangerous Drugs estimated that in 1986 the United States imported 150 tons of cocaine, 12 tons of heroin, 30,000 to 60,000 tons of marijuana" (p. 27).

Mendoza (1994) indicated that three critical factors must be considered as one ponders the health status of Latino children. "The heterogeneity of the Latino population, including distinctive immigration histories for each subgroup, the geographic concentration of specific Latino subgroups and the high rates of poverty among Latino families and children" (p. 51). Unlike the Cuban-Americans, Central Americans have not been given political asylum. Many of them are illegal residents in this country and they cannot return to their country because of the political turmoil, making them individuals without a country. "Mexican-Americans have lived in the United States since the formation of the country and may be U.S. citizens, legal residents, or illegal immigrants" (Mendoza, 1994, p.50). Puerto Ricans, in contrast have a very different history of immigration. All Puerto Ricans are U.S. citizens, making them eligible for all state and federal health care programs. "This universal citizenship has resulted in a back-and-forth migration between Puerto Rico and the United States" (Mendoza, 1994, p. 51).

In summary, a review of the literature indicated that there were numerous factors that contributed to the poor health status of children and adolescents of color. Poor health care often begins at birth, accumulates through the years, and is highly correlated to socioeconomic circumstances. Isaacs (1993) asserts that "the increase in health risks behaviors during adolescence, in combination with limited access to health care and effective or available prevention and health education, place adolescents of color at significantly higher risks for many diseases and problems" (p. 36).

Some of the health dangers and problems that have often been associated with this group are pregnancy, sexually transmitted diseases which include human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), chronic or other infectious diseases such as hepatitis, substance abuse, emotional problems, and violence. All of these issues or diseases led to high levels of premature morbidity and mortality among adolescents of color.

Finally, there were many important variations in lifestyle cross-culturally that affected health status. These involved issues related to family structure, values, attitudes, and cultural health habits. For example, Lewit & Baker (1994) indicated that appropriate health and mental health interventions to immigrant children or native-born children of immigrants have been complicated by the parents' uncertainty with how to negotiate the social service system and, in some cases, a fear that involvement with health or mental health services may jeopardize their continued residence in this country.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The goal of the practicum was to develop services that expanded the availability and accessibility of preventive health and primary health care services to 6th, 7th, and 8th grade young adolescents who attended two elementary schools in this city. The Young Adolescent Health Project (YAHP) developed a comprehensive approach to health promotion and disease prevention that provided students with access to medical, dental, vision care, and health education. Although many of the students were not recipients of primary health services, the project was designed to provide all students in the targeted grades with primary prevention activities. Several strategies were developed in collaboration with the teachers and school nurses to increase student awareness about health related issues. These included such activities as classroom presentations, workshops, health focused student councils, and school-wide health campaigns. Also, YAHP staff facilitated collaboration with several health providers and other community agencies in order to increase the resources available to the schools.

Expected Outcomes

The following goals and outcomes were projected for this practicum:

1. At the end of the 8 month implementation period, 80 of the 100 targeted students enrolled in the 6th, 7th, and 8th grades of two elementary schools would have been assessed by a multi-disciplinary case management team for individual health needs, high risk behaviors, and their knowledge about health issues.
2. At the end of the 8 month implementation period, access to medical, dental, and vision care would have been facilitated for all of the students who were identified by the assessment as needing service.
3. At the end of the 8 month implementation period, 40 of the 80 assessed students would have received medical and/or dental attention from one or more service providers.
4. At the end of the 8 month implementation period, 1/2 of the total students in the 6th, 7th and 8th grade students in both schools would have participated in at least 7 of the 10 prevention workshops provided at each school.
5. At the end of the 8 month implementation period, a comprehensive, integrated service delivery system would have been established among the three primary health providers to meet the health needs of the targeted students.
6. At the end of the 8 month implementation period, the importance of the collaborative process would be recognized by 10 of the 12 project participants who were responsible for improving student health access.

These participants included personnel from The Health Center, Planned Parenthood, School Based Youth Services Program and the Schools. Their ongoing working relationships would have help them de-emphasize the issues of power, authority and domain which often impede the collaborative process.

Measurement of Outcomes

The evaluation instruments used in this practicum were developed by the writer in collaboration with the other Alliance for Teen Health partners. They were as follows:

1. The evaluation instrument used to measure needs, knowledge, and risk behaviors of each student was a health assessment questionnaire. (See Appendix A)
2. The evaluation instrument used to measure access and utilization was the Treatment Plan Contact form maintained on each registered student in the program. (See Appendix B)
3. The evaluation instruments used to track the services provided students were the Treatment Plan Contact form and the computerized 'level of service' reports generated and maintained by each agency. (See Appendix C for 'level of service' form)
4. The evaluation instrument used to measure the number in attendance and the number of students consistently attending the workshops were sign-in sheets at each workshop.

5. The evaluation instrument used to determine the efficacy of the integrated service delivery system of this project was the computerized program that was shared by the three agencies. (See Appendix D for the prototype of the *Microsoft Windows®* application worksheet)
6. The evaluation instrument used to measure the staff attitudes about the quality of inter-organizational relationships and the collaborative process was the Interagency Collaboration Survey. (See Appendix E)

Analysis of Results

At the end of the eight month implementation period of the practicum, the writer collected and analyzed the information from the evaluation instruments. The data gleaned from the instruments were important, but the insight gained into the collaborative process was also very useful. It enabled the partners to discover the barriers to the implementation of a health project in a public school district.

Before the health questionnaire could be completed, students were required to return a signed parental consent form. (See Appendix F) Eighty consent forms were received during the implementation period. The following information was acquired from the instruments:

1. The health questionnaire survey provided baseline information which included the health status, at-risk behaviors, and the present level of primary care of the students. Additionally, the health questionnaire survey was designed to identify the following demographic information and common adolescent concerns:

a. The survey rendered information about the client's family composition which included the household types of two parent, single parent, or other; age, sex, gender, language spoken, and racial/ethnic background.

b. Questions about prior involvement with medical providers were designed to indicate the student's use of health services and to identify previous treatment and medications.

c. Questions were included that identified health issues that applied specifically to males or females.

d. Questions related to at-risk behaviors were also included in the survey.

2. The Treatment Plan Contact Sheet was designed to assist the case management team in monitoring continuity and utilization of services at each agency. The form was kept in the case record as it provided a summary at-a-glance of the types of services, referrals, and follow up appointments scheduled and kept by each student. Also, it served as a worksheet for the monthly computerized health Level of Service Report maintained by the Alliance of Teen Health agencies.

3. The Level of Service Report (LOS) was developed by the State Department of Human Services as a way to categorize all of the services provided by the School Based Youth Services Program.

There are several sections that address the many aspects and services of the SBYSP. They include mental health, health, employment, substance abuse, recreational, and day care. The Alliance for Teen Health used the computerized health section of the LOS report as an instrument to track and monitor the students in the health programs.

A local area network system was not established for the partners during the implementation period; however, the State Director of SBYSP granted permission for the health section of the LOS Report to be installed into the other two partners' computers so that tracking could be established and maintained. The LOS allowed the students' contacts to be monitored by each agency, but provided a seamless delivery system for the individual student. In addition to basic demographic information, this report provided the date of visit, name of agency, purpose of visit, and procedures provided during visit.

Collaboration among the various partners was crucial to the success of the Young Adolescent Project. In order to maintain the personal focus on the needs of the individual clients, special attention to building and maintaining relationships among the partners needed to be fostered. This approach to health service delivery also required different levels of coordination. Formal and informal interactions took place during the monthly ATH meetings and through networking among the partners and staff members.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

This practicum was concerned with increasing the availability and accessibility of preventive and primary health care services to young adolescents in the 6th, 7th and 8th grades in two elementary schools. In order to achieve these goals, it was essential to develop various services and strategies. Students needed to increase their knowledge about prevention and gain assistance in developing the skills necessary to make informed decisions. According to Perrin, Guyer, & Lawrence, (1992) "Effective programs for adolescents help them to develop self-care skills, encourage exercise and appropriate diet, and decrease major risks to health such as smoking, alcohol use, and other substance abuse" (p. 69).

The Guidelines for Adolescent Preventive Services (GAPS) provided a framework for comprehensive preventive health services with twenty-four recommendations in the areas of health guidance, screening, and immunizations. (American Medical Association, 1992) A review of the literature indicated that current research provided support for the messages provided in the GAPS recommendations, but expanded the scope of health promotion to schools and community settings, as well as health and clinical settings. (Pentz,1993)

Health promotion interventions usually take the perspective of a public health approach which focuses on improving the health status of a population. In contrast, the medical approach is a micro-level approach that focuses on the individual at high risk for health-compromising behaviors. (National Institute of Nursing Research, 1993) Health education in schools has utilized the population-based public health model which provides information on family life education, drug and alcohol abuse, violence, mental health, and nutrition. (NINR, 1993) The U.S. Office of Technology Assessment (1991) criteria for health education in schools included developmentally appropriate information, skills training in making decisions and dealing with peer pressure, and participation in physical activity programs that foster lifelong exercise habits.

Millstein (1993), reviewed adolescents' health related perceptions and found that "adolescents generally consider health promoting behaviors to include the following: proper nutrition, regular exercise, getting enough sleep, seeing the doctor or dentist, maintaining personal hygiene, maintaining a healthy weight, dressing properly for weather, avoiding temperature extremes, taking vitamins, avoiding injury, staying away from sick people, having a positive attitude, and avoiding negative feelings" (p. 6). Furthermore, she believes health promotion interventions should recognize the importance of including adolescents' desires, motivations, and priorities, rather than making the adult perspective the definitive standard from which health promotion programs are developed. In addition to schools and health facilities, family members, peers, and the media should be considered as opportunities for health promotion.

There are many successful models which eliminate barriers to preventive health and primary care services for adolescents. These programs address the issues of accessibility, availability, affordability, and acceptability. Strategies for health promotion and primary care that work incorporate a comprehensive approach focusing on both the adolescent population as a whole and individuals within the population. In the report, Health Promotion for Older Children and Adolescents, Schorr & Schorr (1988) and Dryfoos (1990) described successful programs that effectively promote health: they were "flexible, intensive, comprehensive, accessible, and culturally and developmentally appropriate, and the services are delivered by caring, respectful professionals." (NINR, 1993, pp. 48-49)

Since education, health, and social service comprise the human services delivery system, developing children require services in all of these components. The problem, however, is that traditional human services delivery systems have been fragmented, specialized and complex. Many families have problems in access and receipt of services because of decreasing income, deteriorating family structure, multiple problems, and diminished community resources. (Morrill, 1992) The Center for the Future of Children, (1992) indicates that "proponents of integrated services believe that poor education, health, and social outcomes for children result in part from the inability of the current service systems to respond in a timely, coordinated, and comprehensive fashion to the multiple and interconnected needs of a child and his or her family" (p. 8).

In response to the problems of serving children with multiple needs, support for an integrated service approach has been launched across the country. School linked and/or school based services have developed with diverse approaches. Beginning in the 1970's, school based health centers have combined approaches to develop both macro and micro level health promotion that incorporated primary, secondary, and tertiary health care prevention strategies. (NINR, 1993) "Comprehensive school based clinics, . . . are thought to be a promising strategy for reaching adolescents and, in particular, for improving opportunities for adolescents to avoid unintended pregnancies" (Perloff, 1992, p.87).

While the earlier school based health centers focused primarily on pregnancy prevention, more recent models have focused on health promotion, substance abuse prevention, and mental health. (Dryfoos, 1993) These efforts have targeted both students at risk for dropping out of school and other students. Some have provided direct service at the school site; others have emphasized case management for referral and follow-up. Millstein (1993) maintains that "School based and school linked health centers have the potential of not only linking adolescents to needed health services, but also of creating linkages between health promotion in the school and health promotion in the health setting." (p. 10). She also notes that adolescents believe the elements of compassion, communication, and confidentiality are the essential components of an acceptable adolescent health program.

Description of Selected Solution

A school based Young Adolescent Health Project was developed to provide comprehensive health care services and health promotion activities for the 6th, 7th, and 8th grade students in two elementary schools. This delivery system represented an expansion of both the Alliance for Teen Health (ATH) and the School Based Youth Services Program (SBYSP). The ATH was a collaborative partnership established to deliver health services to adolescents in high school. The successful model of providing health services through outreach and facilitation allowed the ATH partners to receive funding to expand to the elementary schools. The SBYSP, which personified the comprehensive model of integrated services identified in the literature, was already providing mental health and recreational services on site at the elementary schools. However, the grant provided additional staff and services to develop a health component in the elementary schools.

The 6th, 7th, and 8th grade students were screened for biomedical, behavioral, and emotional issues that required treatment, or the development of a prevention strategy to increase knowledge about at-risk behaviors and disease prevention. In addition to the screenings, scheduling of health appointments, advocacy and follow-up, transportation, and supplemental health education were provided. The specific medical services that were offered included: dental and vision care; laboratory tests; management of chronic illnesses; GYN/reproductive health services; and individual counseling. Health guidance and promotion activities were provided through information-sharing workshops, a peer health education program, and skills development workshops which taught students to assess their own health-promoting or health-damaging behaviors.

Also, during the health assessment interview the counselor/nurse was able to individualize and personalize health compromising behaviors for each student. The following processes or strategies were implemented to address the issues of accessibility, availability, affordability, and acceptability:

1. Referral/Intake Procedures: In collaboration with the school nurse, the project staff conducted the health interview/questionnaire as the first step in the initial screening.
2. Treatment Plan Contact Form: This form was used to monitor needs, access, and utilization of services for students from the various health providers.
3. Non-traditional outreach: Classroom presentations were made to facilitate contact with students and help them connect education to health promotion. Parental consent forms were distributed; as an incentive, each student would receive a tee shirt if the consent was returned with a parent's signature.
4. Data Management: The Level of Service (LOS) monthly report allowed information to be shared in a coordinated manner by the partnership agencies which reduced overlap or gaps in services.
5. Confidentiality: The consent forms notified parents of the sharing of demographic information. However, it was also made clear that any information gathered by one of the agencies to facilitate treatment was considered confidential. Each agency developed and maintained individual case records that could not be released without expressed written consent.

6. Affordability: The health center is a federally qualified health center (FQHC) with federal funding which allows some coverage for the indigent through sliding fee scales or charity care support. The second partner is Planned Parenthood which also uses a sliding fee scale. Any clients who are not eligible for Medicaid or other insurance coverage and cannot afford any fees, are paid for by the SBYSP.
7. Acceptability: One project staff member is bi-lingual and bi-cultural. This is in recognition of the importance of acknowledging the social/cultural milieu of each student.

Report of Action Taken

The implementation of the Young Adolescent Project covered an eight month implementation period from February through September, 1996. On January 23, 1996, the Directors of the Alliance for Teen Health met with the Superintendent of Schools and his Administrative Council to discuss the expansion of the health project to the elementary schools. This meeting was seen by the writer as an update for the central office administrators and no problems were anticipated. Although the health assessment questionnaire survey had been used in the high school without prior parental consent, the business manager on the Council insisted that consent be acquired prior to its use with elementary school students. In the past, parental consent had been secured after the questionnaire was completed and only when the student needed specific health services. This instrument was also used to develop group health prevention and promotion activities based on the overall needs identified by the questionnaires.

As a result of the Council meeting, the procedures were changed for both the high school and the new project. This policy change required the project staff to engage in aggressive outreach to disseminate and obtain signed parental consent forms in order to start in February. In order to expedite the return of parental consent forms, tee shirts were given to students as an incentive.

The implementation of the Young Adolescent Health Project in the two schools was welcomed and enthusiastically embraced by the principals, nurses, and teachers. They encouraged students to participate and return signed parental consent forms. The nurses identified the students and personally met with them to stress the importance of the project and to urge them to return their consent form. In one school, the nurse agreed to share her office during the administration of the questionnaire. In the other school, the principal volunteered the use of her conference room. All of the teachers scheduled classroom time for health presentations. Even though all of the workshops were initially scheduled for after school, one school preferred to have them conducted during the school day. The other school workshops were conducted after school as part of the established after school program.

Certain 8th grade students were selected to serve on an advisory council to help plan workshops, develop action plans, and create other projects of interest. In order to be selected, students had to express an interest in participation, be identified by teachers as mature and responsible, and demonstrate that they were maintaining passing grades. It was important to recruit students who were most likely to graduate because they would be trained for the high school health program.

Maturity was important because the high school program was designed for junior and senior students. The inclusion of the younger students in the high school health project represented a change in policy. It seemed however, that the change to include the younger students was justified because they were already involved in health promotion activities. Also, the writer believed that there was a direct relationship between students' participation in health promotion activities, attitude, and behavior changes. Thirteen of these students were trained during July and August for the HiTops (Health Interested Teens Own Program on Sexuality) peer health education program at the high school. The summer program served as a bridge to high school and prepared the students for a three day retreat with the high school upper classmen involved in the HiTops program in late August.

The Management and Case Management Teams were responsible for the overall functioning of the health project. The Management Team included the directors of the three health providers and the project coordinator of the ATH. They met 9 times during the 8 month implementation period. During these meetings, forms were designed and the program was monitored through verbal reports and a review of the Level of Service Reports. The Case Management Team consisted of the coordinator of the project, employed by the health center, a part-time nurse and a part-time health educator, both employed by Planned Parenthood, and a psychologist, employed by SBYSP. This team met weekly to develop treatment plans and monitor the appointment referrals for each student.

Although the participants in the project were positive and enthusiastic, there were some difficulties encountered during the implementation process. As mentioned, the signed consent forms were critical to the success of the project.

In one school, several of the returned forms were misplaced either by the teachers or enroute to the nurse. They were never received by the project coordinator. In addition, there were many more Latino children who could not speak English than had been anticipated. The full-time project coordinator was not bi-lingual and the part-time bilingual nurse was only employed ten hours per weeks. Consequently, completion of the assessment for the Spanish-speaking children took more time than anticipated.

The experience of implementing a health project raised questions and problems that were not foreseen or planned for in advance. Accessibility, affordability and acceptability are very complex and difficult health care issues to manage and deliver to a population. Even though there were several support services available, all of the children in the study did not access the services. The more difficult services, such as transportaion, were provided by the project.

While there were 330 students enrolled in the 6th, 7th, and 8th grades, only 110 signed parental consent had been returned at the time of this report. The Young Adolescent Health Project (YAHP) staff recognized the fact that all of the students would not receive, or needed to receive health care, however, the health assessment process gave the counselors the opportunity to provide some anticipatory guidance about health risk factors and other concerns that the students might express during the interview. It was apparent from the slow rate of the return of the consent forms that the YAHP staff needed to more effectively communicate to the parents that written consent not only gave access to health care, but it was used as a way to identify behaviors and encourage discussion with each child about prevention of disease and promotion of healthy behaviors.

The school nurse approximated that one third of this population had private insurance and did not see the need to enroll in the program. Another level of parental refusal occurred when referrals for treatment were indicated. These parents had signed the consent for participation in the YAHP, but refused a referral to an outside health provider or any kind of mental health services. Staff speculated that parental refusal possibly reflected a fear about non-familiar organizations that might affect the immigrant status of some of the families.

Another barrier was the disappointing problem related to the YAHP's inability to address the issue of accessibility for children and families who had insurance, but who could not afford the deductible premium. Nineteen families continued to use the emergency rooms for care because they had no primary care physician. In addition, involvement in any type of prevention activity was almost non-existent among this group. Most of them only accessed health services when they were very ill and desperate. Most of these children had never seen a dentist.

The system of the YAHP was designed primarily for students without insurance, or Medicaid and Medicaid eligible families. The sliding fee structure of the health providers could not accommodate deductible premiums. The School Based Youth Services Program only paid for emergency needs that were not covered by the other health providers. For example, medications, eye glasses, and emergency procedures that eliminated pain, such as tooth or earaches were often underwritten by SBYSP. However, these eligibility features did not include or address the problems of the insured population.

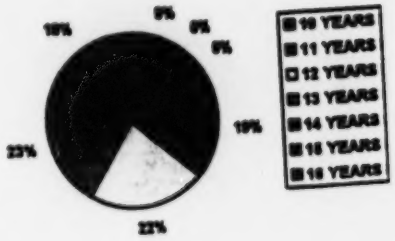
In conclusion, the process of implementing a collaborative health project in two elementary schools was a worthwhile undertaking, but it had many 'entry' problems that could not be resolved within the eight month time frame. However, the evaluation process itself helped the Alliance for Teen Health partners to re-define the goals and objectives. It also highlighted the areas that will need adjustment, re-thinking and refinement.

CHAPTER V

RESULTS, DISCUSSION AND RECOMMENDATIONS

Results

The Young Adolescent Health Project (YAHP) was a unique approach to health care because it actively reached out to students, rather than relying on students to self-initiate health care. It also created a network of services for students, and increased collaboration among health providers and the schools. During the time period of February through September, 1996, 80 students had health assessments completed and approximately 200 students participated in the health workshops conducted during class periods and/or after-school; 46 students were scheduled and seen by a health care provider during this period; an additional 20 students were scheduled for a medical or dental procedure, but had not yet been seen at the time of this report. The demographic information which describes the 80 students is found in Figure 2 .



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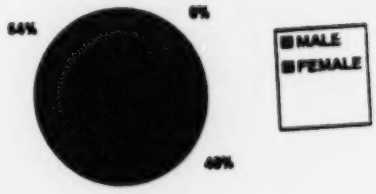
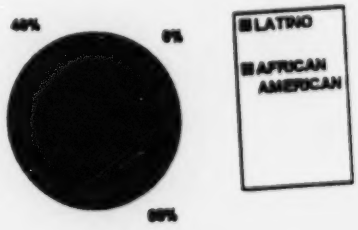


GENDER



ETHNIC GROUP

Figure 2. N=80 The demographic information illustrated in the above figures represent the percentage of students according to age, gender and ethnic group.

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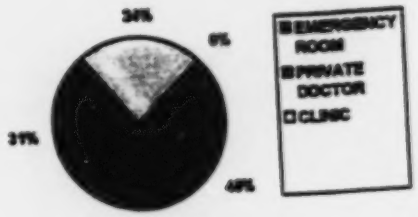
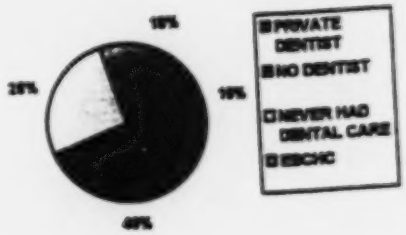
The writer hypothesized that accessibility, availability, and acceptability of preventive and primary health care services would increase for 6th, 7th, and 8th grade students in two elementary schools if the following outcomes were met:

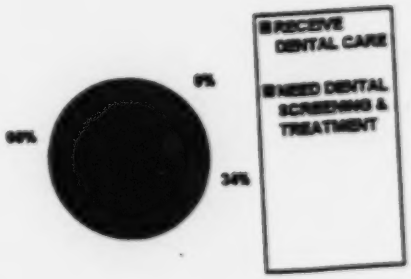
Outcome # 1: At the end of the 8 month implementation period, 80 of the 100 targeted students enrolled in the 6th, 7th, and 8th grades of two elementary schools would have been assessed by a multi-disciplinary case management team for individual health needs, high risk behaviors, and their knowledge about health issues. In order to evaluate this outcome, the Health Assessment Questionnaire, developed by Alliance for Teen Health partners, was administered to 80 of the targeted students. It was used to measure needs, knowledge and the risk behaviors of the students. This questionnaire revealed some interesting information about the health needs of this population. The responses to questions about who provided medical and dental care, and where the services took place, exemplified the need for this health project. As suspected, many of the children did not have a doctor or dentist. In fact, the responses revealed that many children had never seen a dentist and/or had not seen a doctor for several years. The Hospital Emergency Room was the most frequent response to the question of where medical care was provided. Thirty-six of the 80 students had only received emergency health care. Routine check-ups and preventive care were not part of their experiences. Figure 3 depicts the responses to these questions.



SOURCE OF MEDICAL CARE



SOURCE OF DENTAL CARE



DENTAL CARE NEEDS

Figure 1. N=80 The top two figures indicate the percentage of students who use the different types of medical and dental resources. The bottom figure represents the percentage of students who needed dental care.

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The health assessment proved to be an effective way to identify problems and make interventions. The 19 symptom checklist allowed the case management team to easily identify the needs of the students. Students most frequently identified symptoms of headaches and stomach aches; 52 students complained about headaches and 38 complained of stomach aches. Since these complaints are common among children, additional symptoms were assessed to determine the nature of the problem and the type of referral needed. For example, many of the students who complained about headaches also complained about allergies and/or asthma. Table 1 shows the number of complaints for each symptom.

Table 1. Symptoms Students Identified as Problematic

N=80

Symptom	Number of complaints	Symptom	Number of complaints
Headaches	52	Allergies	19
Stomach aches	38	Asthma/bronchitis	23
Diarrhea/constipation	11	Colds/flu	21
Feeling run down	22	Persistent cough	2
Ear/hearing problems	12	Dental problems	14
Speech problems	0	Heart problems	2
Visual problems	22	Chest pains	13
Acne/skin problems	6	Dizzy/fainting spells	6
Stress	6	Convulsions/seizures	1
		Fever/chills	13

It was interesting to find that only 14 students identified dental problems as a complaint, since 21 students had never seen a dentist and 32 had not seen a dentist for several years. It was clear from the responses that the Health Assessment Questionnaire had uncovered physical, educational, emotional, and social problems that probably would not have otherwise received attention or treatment. Therefore, the number of students who were assessed for health needs met the writer's standard of achievement.

Outcome # 2: At the end of the 8 month implementation period, access to medical, dental, and vision care would have been facilitated for all of the students who were identified by the assessment as needing service. This outcome was met based on the definition of *facilitation* as providing "access" to medical services. The Project staff served as intermediaries or advocates to achieve health access for all of the students who were assessed. Despite the advocacy, many students did not receive a medical intervention.

Unanticipated circumstances beyond the control of the writer prevented students from receiving needed services. While the difficulty of scheduling appointments within a reasonable time period impeded access, it did not end the process; however, the process was terminated when parents refused to cooperate. The project staff found one barrier insurmountable; parents unwillingness to accompany their child to the initial medical appointment. The Health Center, like all other health facilities, requires parents to complete appropriate forms before any medical or dental procedure can be performed. It was frustrating for the staff to secure an appointment and have the child miss it because the parent refused to accompany the child.

Parents claimed they were working and/or found advance scheduling too difficult to manage. Other parents were ill and claimed they knew no other adult to serve as a surrogate; some were out of the city or country; and others just failed to respond. Consequently there were several missed appointments or students were not scheduled for a needed service because parents were uncooperative.

The dental problems created a different kind of "access" challenge. There were no private dentists who were willing to take new Medicaid or charity care patients. It became apparent that there was a scarcity of dental services for indigent patients. The Health Assessment Questionnaire identified that the number of students needing dental services far exceeded the ability of the system to respond within an 8 month period. Project staff realized that the scheduling and screening of all of the children identified by the assessment for dental appointments would take at least a year. However, the Alliance for Teen Health was able to secure a block of time exclusively for students.

The 22 children identified with vision problems were all seen during the 8 month implementation period. The access issues were not nearly as difficult because of the commitment of one local optometrist. This gentle, unassuming man performed eye examinations on all of the identified children free of charge, and provided glasses for the majority of students who needed them. The writer believes that facilitation of access to medical, dental and vision services was achieved despite some of the described problems.

Outcome # 3: At the end of the 8 month implementation period, 40 of the 80 assessed students would have received medical and/or dental attention from one or more service providers.

A total of 46 students were seen for various needs during the implementation period. Fourteen students had seen a dentist and 8 students were scheduled for dental care. The other 31 students who needed dental care will be scheduled in the near future. The 22 students who complained of visual problems all received services during the 8 month period. Medical services, like dentistry, usually required a follow-up visit. At the time of this writing, 10 children had been seen for the initial medical visit and 12 others were scheduled. Table 2 depicts the number of services received, scheduled, and waiting disposition.

Table 2. Number and Type of Health Services Provided

N=80

	Medical	Dental	Vision
Services Received	10	14	22
Appointments Scheduled	12	8	none pending
Awaiting Disposition	3	31	none pending
Total services		46	
Total scheduled appointments		20	
Total awaiting disposition		34	

The number of students receiving medical, dental and vision services exceeded the writer's standard of achievement.

Outcome # 4: At the end of the 8 month implementation period, 1/2 of the total students in the 6th, 7th and 8th grades in both schools would have participated in at least 7 of the 10 prevention workshops. This outcome was measured by the number of students who participated in the after-school workshops and the classroom topical presentations. There were 330 students in the 6th, 7th, and 8th grades in both schools; 200 attended the workshops and classroom presentations.

As mentioned, after school workshops were not possible in one of the schools, therefore classroom topical presentations were substituted. After school workshops and advisory board meetings were established in the after school program of the other school. Attendance was increased by having a captive audience. However, attention and active participation was more noticeable in the after-school workshops. These results exceeded the expected standard of achievement.

Outcome # 5: At the end of the 8 month implementation period, a comprehensive, integrated service delivery system would have been established among the three primary health providers to meet the health needs of the targeted students. The Level of Service Reports (LOS) computer based program served as the instrument for coordinating, tracking, and monitoring the students as they accessed the services of each provider. Demographic information, agency codes, visit date, type, and purpose were shared among the partners of the Alliance for Teen Health. Furthermore, cross checks among agencies assured continuity of services.

The other key ingredient to establishing a comprehensive integrated service system was the monthly management meetings where system problems were discussed. Modifications of forms, as well as different approaches to support relationship building or time line changes were often discussed. The standard of achievement for this outcome was met.

Objective # 6. At the end of the 8 month implementation period, the importance of the collaborative process would be recognized by 10 of the 12 participants involved in the project who were working to achieve the goal of health access for students. These participants included personnel from the Health Center, Planned Parenthood, School Based Youth Services Program and the Schools. Their ongoing working relationships helped them de-emphasize the issues of power, authority and domain which often impede the collaborative process. The Interagency Collaborative Survey revealed that the participants involved in the Young Adolescent Health Project (YAHP) believed that the collaborative efforts had been successful and had made a positive difference in the lives of the students. The following comment summarized the view of the partners: "We have genuine commitment to client service from all partners which motivate us to be flexible, creative and collaborative in responding to student needs." Therefore, the results of this survey indicate that the standard of achievement for this outcome was met.

Discussion

The success of medical inventions and interventions has made the health industry in the United States the most successful in the world. However, it rates below several industrial nations in providing access to its total population.

While accessible health care is the primary focus of this project, it cannot be forgotten that poverty is the actual issue that affects health care access and the health status of this population. One student in particular underscored the relationship of poverty to the health status of the adolescents in this study. During the assessment interview, he reported that he was having stomach aches because he skipped meals, he indicated that his family was often without food.

The health assessment interview also provided the opportunity for the students to raise questions or show interest in certain areas. Curiosity about high risk behaviors provided the opportunity for health guidance. Pamphlets on sexually transmitted diseases, drugs, and reproductive health were distributed. Another example of health guidance occurred when the interviewer completed the family history which identified various conditions of each student's family members. The interviewer informed the students about the importance of understanding these conditions and thinking about activities and lifestyle changes that can help them avoid similar problems. It was further explained that each person had a propensity for certain conditions based on family history and lifestyles. Since the prevention and promotion aspects of the project was designed to encourage a better understanding of psycho-sexual development, avoidance of tobacco, alcohol, and other abusable substances, additional personal instruction was given through the workshops and classroom presentations.

The development of the YAHP required careful coordination and planning among the partners, as well as acceptance by families of an aggressive outreach approach to health care and prevention services.

The practicum utilized the evaluation research model to examine and identify the challenges encountered and the benefits gained during the implementation. Since "evaluation is the process of delineating, obtaining, and providing useful information for judging decision alternatives," the writer was interested in applying this type of research to a newly developed approach to school health (Stufflebeam, 1985, p. 153). Evaluation research is appropriate for recently implemented projects because it provides useful information as it develops. The procedures and information gleaned from this study will inform and direct the future activities of the Alliance for Teen Health. Furthermore, the experiences of this collaborative effort can inform others about some of the issues involved in making health services available to school aged children who are poor and disadvantaged.

The decision-facilitation model which utilizes four types of evaluation is called CIPP. (Stufflebeam, 1985) "CIPP" is an acronym representing context, input, process and product. "A context evaluation attempts to isolate the problems or unmet needs in an educational setting" (Popham, 1993, p. 35). Consideration was given and a determination was made about developing a program that would begin to address the dental, vision, and medical needs of the 6th, 7th and 8th grade students identified by the school nurse. This analysis led to goals and objectives that could most likely be achieved during an eight month period. Records were maintained by the school nurses and the project staff. The health assessments were used to determine self-reported health problems and develop prevention and promotion activities based on identified knowledge gaps. Access was improved by providing direct care or by taking actions to reduce barriers such as scheduling appointments, providing transportation or paying the bill.

According to Stufflebeam (1985) "the main objectives of this type of study are to assess the overall status, to identify its deficiencies, to identify the strengths at hand that could be used to remedy the deficiencies, to diagnose problems whose solution would improve the well-being, and, in general, to characterize the program environment" (p. 169).

Input evaluation provided information about how to identify relevant approaches and resources to achieve objectives. According to Popham (1993), "the task is to ascertain the nature of available capabilities of the system and potential strategies for achieving the objectives identified as a consequence of context evaluation" (p.36). The development of a consortium of health providers to offer services to the schools was one part of the plan of action. This was accompanied by strategies for intervention based on the literature review and the success of other programs.

The process evaluation was the most important aspect of this evaluation because it was an ongoing check of the health program implemented for the 6th, 7th and 8th grade students. The nature of the key relationships and roles in this consortium of health providers was significant in enabling the students to experience a seamless system of care. The beliefs, feelings and attitudes about the collaborative relationships between the partners, the health project staff and the school personnel were crucial to the success of the program.

The methodology utilized to provide the ongoing check on the implementation included case records which identified the health needs of each student, types of referrals and visits, appointments, etc.

Also, a key ingredient of the success of the process evaluation was the tracking of each student in the different provider systems. The partners used the 'Level of Service Reports' to accomplish this goal. In addition to developing policy and procedures, the monthly management team meetings were used as feedback sessions. Staff were encouraged to discuss successes, as well as, any part of the process that needed adjustment or elimination.

Finally, the product evaluation determined the extent to which the health program for the 7th and 8th grade students achieved its goals and objectives. At the end of the eight month implementation period, the writer believed that the following questions produced positive responses in most instances: Did the health project meet the needs of the targeted students? What were the effects of the project? How do the outcomes compare to the stated objectives? It was established in the previous section that the outcomes of the health project were favorable for the majority of the targeted population. The emphasis of the product evaluation, according to Popham (1993) "...is clearly on the outcomes produced by the program. This outcome is related to the objectives of the program; then comparisons are made between expectations and actual results" (p.36).

Recommendations

The following recommendations will be helpful to program developers interested in increasing affordable and accessible health services to disadvantaged, minority school children:

1. Consider the systems issues that contribute to the compromise of the mental and physical well-being of minority populations.

a) limited access to community-based comprehensive and primary health care services;

b) lack of culturally and linguistically appropriate health promotion/disease prevention activities.

2. Develop cooperative relationships among health providers who are willing to combine resources and develop funding strategies to re-shape existing programs or create new initiatives.
3. Initiate health coalitions that will institute ongoing outreach, provide health education, and health promotion activities for children.
4. Increase primary and preventive medical, dental, and mental health services through collaboration and cooperation.
5. Ensure continuity of care by providing case management, a regular source of health care, and other services that will facilitate access for children.
6. Enhance collaboration by using technology to create a management of information system that will facilitate communication, reduce duplication of efforts, and improve the delivery of services to the clients.
7. Acknowledge the issue of access as complex and multifaceted, but at the same the need for a serious commitment from the partners to improve health outcomes for children.
8. Institute formative evaluation strategies to maintain an ongoing check of activities related to the project.

Dissemination

Schools and community health agencies can use the strategies identified in this practicum report to improve the health outcomes of poor children.

Interagency linkages often promote communication and cooperation among various community agencies. The advantage of the specific linkage between schools and health agencies is that services can be provided and facilitated beyond what is generally offered by school districts. The United Way in this community recognized this possibility by funding the project through their "Innovative Venture Grant Program." The United Way will take the lead role in disseminating the results of this health project by making the information available to the other offices across the country. They are particularly interested in the possibility of replication at other sites.

The positive outcomes of this project provide the rationale for implementing such a program in other communities. Initially the United Way provided the seed money to create this innovative program, but wanted assurances that the program would continued past their funding period. The program can be continued at a minimal cost because the systems are intact. Each agency will contribute funds to maintain the coordinator position, since the partners believe the facilitation role is essential to making health care accessible for this population.

The Primary Care Association of this state is an active organization representing the twelve federally qualified health centers (FQHCs) and their satellite sites funded by Sections 330/329 of the United States Public Health Service. Since the Health Center Director in this community serves as one of the officers of this association, the outcomes of this health project will be disseminated among the other FQHCs. Additionally, the writer and the coordinator of the project will present a workshop about the Young Adolescent Health Project at the annual conference of the Primary Care Association.

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Appendix A

Health History Assessment

YOUNG ADOLESCENT HEALTH PROJECT

A program funded by United Way of Central

HEALTH HISTORY

Date: _____

1. Name: _____ Homeroom #: _____ Lunch period: _____
2. Address: _____
3. Phone: _____
4. Birth Date: _____
5. Age: _____
6. Sex: ☐ Male ☐ Female
7. Grade: ☐ 9 ☐ 10 ☐ 11 ☐ 12 Other ____

8. Racial /Ethnic Background:
   - ☐ American Indian/Alaskan Native
   - ☐ Asian
   - ☐ African American
   - ☐ Hispanic
   - ☐ Caucasian
   - ☐ Other _____

9. Language(s) Spoken: ☐ English; ☐ Spanish; Other _____

10. What adults do you live with now? (✓ all that apply)
    - ☐ Mother
    - ☐ Father
    - ☐ Stepmother
    - ☐ Stepfather
    - ☐ Grandmother
    - ☐ Grandfather
    - ☐ other family members
    - ☐ shelter
    - ☐ foster home
    - ☐ other _____

11. How does your family pay for medical care?
    ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ RCHP ☐ Cash ☐ Other

12. Name of Parents/Legal Guardian: _____

13. Name of person to contact in case of an emergency: _____
    Phone # _____

14. How did you hear about the Alliance for Teen Health?
    - ☐ School Based Youth Services Prog.
    - ☐ School Nurse
    - ☐ Guidance Counselor
    - ☐ School Assembly
    - ☐ Friend
    - ☐ Other _____

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15. Where do you receive most of your medical care?

- ☐ Emergency Room
- ☐ Eric B. Chandler Health Center
- ☐ St. John's Clinic
- ☐ Planned Parenthood
- ☐ Private Physician
- ☐ Other _____

16. Who is your regular doctor? _____

17. When was your last visit to a doctor?
    Date: _____
    Reason for visit: _____

18. Where do you go for dental care? _____

19. Who is your regular dentist? _____

20. When was your last visit to the dentist?
    Date: _____
    Reason for visit: _____

21. Are you taking any medication regularly?
    ☐ Yes ☐ No
    If yes, name of medicine? _____

22. Are you allergic to any medicine?
    ☐ Yes ☐ No
    If yes, what medicine? _____

23. Are you allergic to any food?
    ☐ Yes ☐ No
    If yes, which food? _____

24. Do you have any seasonal allergies?
    ☐ Yes ☐ No

SYMPTOM CHECK LIST

During the past year, have you experienced the following:

- ☐ headaches
- ☐ stomach aches
- ☐ diarrhea/constipation
- ☐ feeling run down
- ☐ ear/hearing problems
- ☐ speech problems
- ☐ visual problems
- ☐ acne/skin problems

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- ☐ stress
- ☐ allergies
- ☐ asthma/bronchitis
- ☐ colds/flu
- ☐ persistent cough
- ☐ dental problems
- ☐ heart problems
- ☐ chest pains
- ☐ dizzy/fainting spells
- ☐ convulsions/seizures
- ☐ fever/chills

1. Have you experienced a loss of appetite?
   ☐ Yes ☐ No

2. Have you gained or lost any weight lately?
   ☐ Yes ☐ No

3. Do you ever skip any meals?
   ☐ Yes ☐ No
   If yes, how often? _____

4. Do you have problems with any food?
   ☐ Yes ☐ No

5. Do you ever have problems falling or staying asleep ?
   ☐ Yes ☐ No
   If yes, explain: _____

6. How many hours a day do you sleep? _____

7. Do you feel you sleep too much?
   ☐ Yes ☐ No

8. Do you feel a lot of pressure at home or school?
   ☐ Yes ☐ No

9. Do you frequently feel tired?
   ☐ Yes ☐ No

10. How often do you feel sad or depressed?
    ☐ Never ☐ Occasionally ☐ Almost all the time ☐ Every day

11. Do you ever think about hurting yourself or ending your life?
    ☐ Yes ☐ No

12. Have you ever tried to hurt yourself purposely?
    ☐ Yes ☐ No
    If yes, how many times? _____ When? _____

13. How do(es) the adult(s) that you live with deal with anger?

_____

14. How do you deal with anger? _____

15. Have you ever had a close relative or friend die?
    - ☐ Yes
    - ☐ No

    If yes, how long ago? _____

16. Do you have a problem getting along with your peers?
    - ☐ Yes
    - ☐ No

17. How often do you have physical fights? _____

For Females Only:

1. When did you start menstruating? Date: _____
2. How often do you get your period? _____
3. How long does your period last? _____
4. Have you ever missed your period or had an unusual period?
   - ☐ Yes ☐ No
   - If yes, explain: _____
5. Do you ever experience vaginal bleeding when you don't have your period?
   - ☐ Yes ☐ No
6. Do you experience premenstrual discomfort or menstrual cramps?
   - ☐ Yes ☐ No
7. Do you experience any unusual vaginal:
   - ☐ Discharge ☐ Rash
   - ☐ Itch ☐ Sores
   - ☐ Odor
8. Do you perform a breast self-exam?
   - ☐ Yes ☐ No
9. Have you ever been to a gynecologist?
   - ☐ Yes ☐ No
10. Have you ever had sex?
    - ☐ Yes ☐ No
    - If yes, at what age did you have sex for the first time?_____
11. Do you experience any pain or bleeding during sex?
    - ☐ Yes ☐ No
12. Do you use birth control when you have sex?
    - ☐ Yes ☐ No
    - If yes, what method is most often used?_____
    - How often is this method used? _____
13. What is the main reason you/your partner do not use birth control?
    _____
    _____

14. Have you ever been pregnant?

☐ Yes ☐ No

If yes, outcome of pregnancy? (birth, termination, etc)_____

At what age did pregnancy occur? _____

Number of weeks that pregnancy lasted? _____

Were there any complications during pregnancy?

☐ Yes ☐ No

If yes, explain: _____

15. Do you have any children?

☐ Yes ☐ No

If yes, ages, DOB, birth weight, sex of child(ren)

_____

_____

For Males Only:

1. Have you ever had sex?
   - ☐ Yes ☐ No
   - If yes, at what age did you first have sex?_____

2. Do you or your partner use birth control when having sex?
   - ☐ Yes ☐ No
   - If yes, how often is the method of birth control used?

3. Have you ever gotten someone pregnant?
   - ☐ Yes ☐ No ☐ Do not know

4. Do you have any children?
   - ☐ Yes ☐ No ☐ Do not know
   - If yes, how many and ages? _____
     _____

For males and Females:

1. Have you ever had blood in your urine?
   - ☐ Yes ☐ No
   - If yes, did you see a doctor about it?
   - ☐ Yes ☐ No
   - If yes, what was the outcome (medication, etc.)_____

2. Do you ever experience burning, pain, or discharge when urinating?
   - ☐ Yes ☐ No

3. Have you ever had a sexually transmitted disease?
   - ☐ Yes ☐ No

4. Would you like to be tested, treated or received more information about STD's?
   - ☐ Yes ☐ No
   - If yes, specify: _____

5. Do you have reson to believe that any of your sex partner(s) have used IV drugs or have had sex with IV drug users?
   - ☐ Yes ☐ No ☐ Not sure

6. Have you ever used IV drugs?
   - ☐ Yes ☐ No

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7. Do you have any reason to believe that you have been exposed to the AIDS virus?
   ☐ Yes ☐ No ☐ Not sure

8. Would you like to be tested or receive more information on HIV/AIDS?
   ☐ Yes ☐ No
   If yes, specify: _____

9. Do you drink alcohol, smoke or use any other kind of drugs?
   ☐ Yes ☐ No
   If yes, specify: _____
   At what age did you begin drinking, smoking and/or using drugs? _____
   How often do you drink, smoke and/or use drugs? _____
   How much do you drink, smoke and/or use drugs? _____
   When was the last time you drank, smoked, and/or used drugs? _____

10. Are you concerned that your parents or any other adults that you live with have a problem with alcohol and/or drugs?
   ☐ Yes ☐ No

FAMILY HISTORY:

Have your birth parents, grandparents, brothers, sisters, (specify who for each category) ever had:	YES	NO
Heart Attack		
Stroke		
High Blood Pressure		
Diabetes		
Cancer		
Cholesterol		
Genetic Problems (birth defects)		
Sickle Cell		
Tuberculosis		
Psychiatric Problems (depression, anger, worried)	What Kind:	
Hospitalization or Counseling	Which:	

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CLINICAL REVIEW

1. Is there a certain health issue that concerns your?

   _____

2. Do you have any questions about this survey or program in general?

   _____

3. Would you like to be a participant in the Alliance for Teen Health Program?
   ☐ Yes ☐ No

ADMINISTRATIVE INFORMATION

1. Information sheet and consent form given to student to give to their parent/guardian?
   ☐ Yes ☐ No

2. Was student cooperative with the interview?
   ☐ Yes ☐ No
   If no, briefly describe attitude and behavior: _____
   _____

3. Place of Interview: _____

4. Interview completed: ☐ Yes ☐ No

5. Signature and Title of Interviewer: _____
   _____

6. Date reviewed: By Social Worker_____ By Nurse: _____

7. Date consent and registration form was returned: _____

Appendix B

Treatment Plan Contact Sheet

TREATMENT PLAN CONTACT SHEET

STUDENT NAME:
AGE: GRADE:
RACE/ETHNICITY:

INSURANCE COVERAGE? REGULAR DOCTOR?

LIVING ARRANGEMENTS:
___ SINGLE MOTHER ___ BOTH PARENTS ___ GRANDPARENT(S) ___ OTHER

IDENTIFIED NEEDS: (Check all areas that need attention)
___ PHYSICAL ___ DENTAL ___ VISION ___ GYNECOLOGY ___ MENTAL HEALTH

VISITS: REFERRALS:

VISIT DATE	VISIT TIME	VISIT TYPE	VISIT PURPOSE	MINUTES	APPT. DATE	PURPOSE CODE	AGENCY CODE	DATE OF FOLLOW UP	COMMENTS

Appendix C

Level of Service Visit Form

SBYSP VISIT FORM (page 1) Visit Form number: _____

1. _____ (First Name) _____ (MI) _____ (Last Name)

2. Client ID number: _____ 4. Visit Time (24 hr clock): _____ : _____

3. Visit Date: _____ / _____ / _____ 5. Visit Type: (circle one) Scheduled / Walk-in

6. Major purpose of visit as stated by: Provider: _____ Client (optional): _____
(fill in one each from the selections below)

1	Crisis	18	Delinquency	34	Immunizations
2	Depression	19	Inappropriate behavior	35	Prenatal Care
3	Suicide	20	Parenting	36	Postnatal Care
4	Self Concept/ Issue	21	Pregnancy issues	37	Health Maintenance
5	Grief/loss	22	Childcare assistance	38	Health Information
6	Sexual abuse	23	Housing assistance	39	Vision/Hearing Screen
7	Other abuse	24	Substance Abuse-student	40	Dental Screen
8	Domestic violence	25	Substance Abuse-Family	41	Scoliosis Screen
9	Victim of violence	26	Substance Abuse Screen/assess.	42	Acute Problem
10	Aggression/Anger issue	27	Substance Abuse information	43	Chronic Problem
11	Family Problem	28	lack of/Job Skills	44	Accident/Injury
12	Peer Problem	29	lack of Job	45	Reproductive Health
13	Sexuality issues	30	Return Visit	46	Gynecology
14	Drop out	31	Routine Physical	47	STD Care
15	Academic problem	32	Athletic Physical	48	Well Child Care
16	Other School problem	33	Weight Management	49	Follow-Up
17	Lifeskills				

7. Problems identified/Diagnoses: (OPTIONAL. Use ICD9 codes List the most serious or important problem/diagnosis first)

A. _____ B. _____ C. _____ D. _____

8. Services Referrals (enter up to FIVE)
At least the purpose of referral code from the list below. Fill in the Agency Code from the Crosstep worksheet. Fill in the appointment date

| | | | | |

VISIT FORM CODES

VISIT TYPE CODES:

Health

12 Reporductive Health
14 STD Care
15 Pregnancy Test
16 Dental Care
17 General Medical Evaluation/Treatment
19 Medical Specialist

Mental Health

31 Crisis Intervention
32 Mental Health Treatment

VISIT PURPOSE CODES:

Health

201 New History
203 Follow-up History
207 Health Maintenance Physical
208 Physical Examination-other
209 Immmunization Given
210 TB Test Administered/read
211 Hearing Screen
212 Vision Screen
213 Scollosis Screen
218 Weight Management

Mental Health

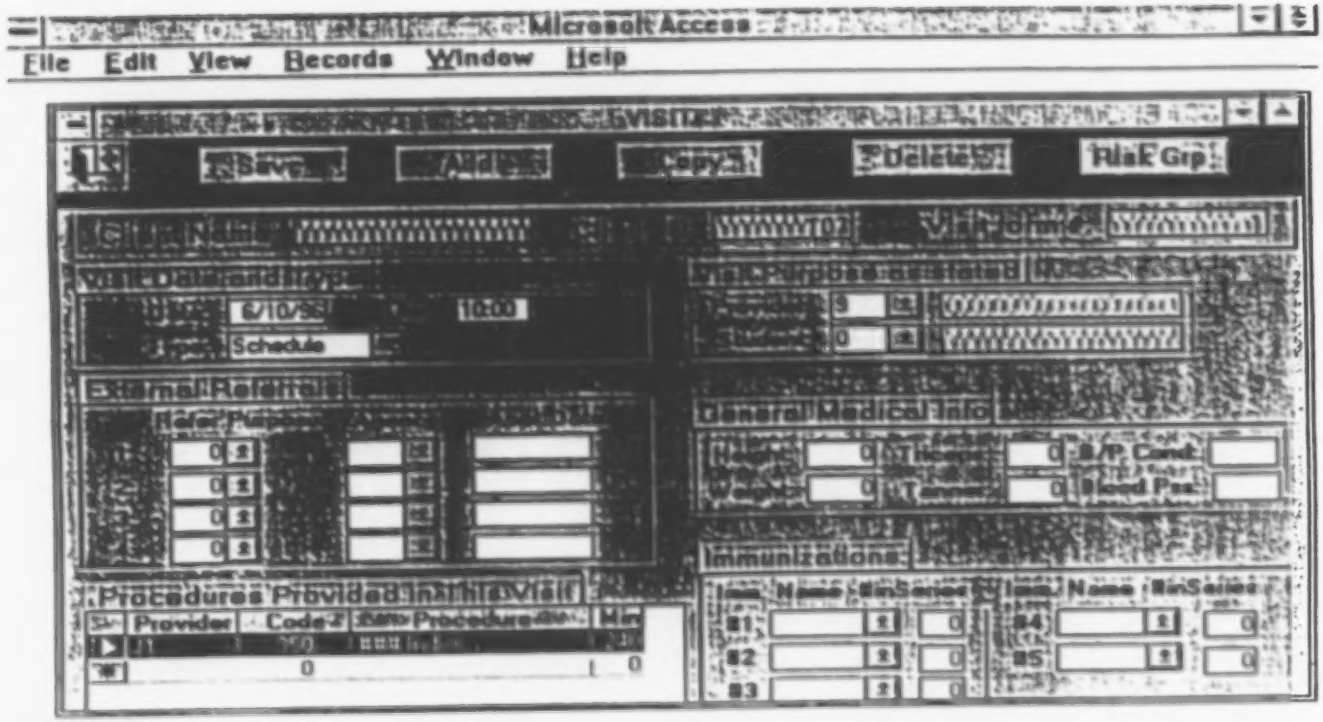
350 Individual Counseling
390 Group Counseling
430 Family Counseling
470 Crisis Intervention

REFERRAL AGENCY CODES:

01 EBCHC- Medical
02 EBCHC- Dental
03 EBCHC- Gyn
04 Planned Parenthood
05 SBYSP- Mental Health
06 RWJUH- Eye Clinic
07 Dr. Harmon- Eye Doctor
08 STD Clinic
09 RWJUH- Dental

Appendix D

Microsoft Windows ® Worksheet Design



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Appendix E

Interagency Collaborative Survey

INTERAGENCY COLLABORATION SURVEY

Please check the response that best describes your impression of the statement

	YES	NO
I BELIEVE		
1. The Alliance for Teen Health (ATH) has been an effective collaborative effort that has successfully facilitated health services for many students in the community		
2. The health providers in the ATH have worked collaboratively and effectively with school personnel to help students secure the health services they need		
3. The ATH has effectively integrated services of several agencies to provide a seamless delivery system for students		
4. The ATH has developed an effective facilitation model that reduces gaps and avoids duplication of health services		
5. The ATH has collaborated to increase the availability and accessibility of primary and prevention health services to both high school and elementary students		
6. The ATH partners constantly work to secure funding to further develop and expand services		
7. Initiatives such as the Young Adolescent Health Project and the HiTops peer education program has expanded services and increased collaboration with other agencies		
8. The ATH partnership has provided the opportunity for members to network and share information about health issues related to teens in the community		

PLEASE COMPLETE THIS SENTENCE

The ATH has been an effective Collaborative because _____

_____

Appendix F

Parental Consent

Young Adolescent Health Project

Dear Parent/Guardian

The Young Adolescent Health Project (YAHP) is a cooperative effort among the Health Center, School Based Youth Services Program, and Planned Parenthood. The goals of the YAHP are to work with youngsters and their parents/guardians to assess the child's health needs, to make it easier for the young people to receive comprehensive health care services, and to provide them with health education.

Services available through the YAHP are offered to students at School. However, if your child is interested in joining the YAHP, but is not a student, please call and I will be glad to direct you to an appropriate program.

Attached is the YAHP consent form. Please sign it and either mail it back to me at the above address, or your son/daughter can return it to Mrs. School nurse.

Thank you for your time and interest in the YAHP. Please feel free to contact me at the above phone numbers if you have any questions or suggestions.

Sincerely,

Alliance for Teen Health
Project Director

Innovative Venture Grant funded by the United Way of

The health care providers listed below will be available to students enrolled in the Young Adolescent Health Project (YAHP) for easy and rapid access to health care services.

I understand that the goals of the YAHP are to emphasize prevention and health promotion, identify and manage health problems, as well as provide referrals for health care services.

I hereby give consent for my son/daughter _____, to receive a comprehensive health assessment conducted by YAHP staff, and health care provided by the Health Center ,, the Planned Parenthood of and/or the School Based Youth Services Program (SBYSP). These services include:

1. Emergency treatment
2. Complete physical examinations
3. Immunization
4. Laboratory testing
5. Dental services
6. Treatment for acute and chronic illness (such as sore throats, asthma, diabetes, and hypertension)
7. Diagnosis and treatment for sexually transmitted diseases
8. Pregnancy testing, prenatal, and postpartum examination
9. Family planning counseling and services
10. HIV/AIDS counseling and testing
11. Professional counseling in regard to nutrition, personal hygiene, sexuality, substance abuse, individual and family problems, and other health related issues.

I understand that my child may only receive immediate referral for treatment or counseling services through the YAHP if I sign this form. I may have to provide additional signed consent/permission for some services.

I understand that YAHP staff will recommend a health care plan, if necessary, based on information obtained from my child and the school nurse as well as give my child information about health and health care providers.

I understand that YAHP staff may speak with the school nurse and with the above mentioned agencies to develop recommendations for a health care plan for my child.

I understand that this allows the YAHP staff to transport my son/daughter to and from appointments at the EBCHC, PPCNJ and SBYSP.

I understand that all information shared about my son/daughter will be kept confidential, and no records will be released without appropriate written permission. In addition, these records will not become a part of the Public Schools' record without appropriate written permission.

I understand that this consent is only valid for the time that my child enrolled in School.

I hereby certify that this consent form has been read and understood, and that I accept the terms of this form.

Signature of parent/guardian

Day time phone number

Date

I hereby certify that this consent form has been read and understood, that any questions I had about it were answered to my satisfaction, and I accept terms of this form.

Signature of student

Date